Exhibit 8

111179

Initial Medical Licensure
PERSONAL INFORMATION
10/2009 INT

STOP! Completed application and check must be mailed to:
MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-1298 Toll Free: 800-492-6836

FOR BANK USE ONLY
Date
Check Number
Amt Paid $600
Name Code
AppID 17

APPLICATION FOR INITIAL MEDICAL LICENSURE

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.): AKODA

First name and middle name: CHARLES JOHN NOSA

(If applicable, please check a box and complete below) ☐ Complete Maiden Name OR ☐ Complete Former Name

Stop! If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.

2. **Public Address:** Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.

Street Address: If you change your address prior to being licensed, immediately notify the Board in writing.

[redacted]

City [redacted] State [redacted] Zip Code [redacted]

3. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

Street Address: (Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.

[redacted]

City [redacted] State [redacted] Zip Code [redacted]

RECEIVED AUG 1 2011 MARYLAND BOARD OF PHYSICIANS

4. **Telephone (s):** Home [redacted] Office: [redacted]

Cell/Pager: [redacted] E-mail address: [redacted]

5. **Date of Birth:** Month Day Year [redacted]

6. **Gender:** ☒ Male ☐ Female

7. **Race:** Multiracial applicants may select all applicable categories ☐ American Indian or Alaska Native ☐ Asian ☒ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

8. **Social Security Number:** [redacted]

For Board Use Only

License Number: D73049 BPQA School Code: 690906

Date Issued: 091411 Federation School Code: 690003

Licensed By: [redacted] Licensing Exam: USMLE

10/2009 INT | Name: [illegible] John Ivosa | Date: 7/28/11

10. **MEDICAL EDUCATION:** List all medical schools you have attended — From: MM/YY To MM/YY

University of Benin College of Medicine, Nigeria — 06/82 - 06/87

Medical School From Which You Received Your Medical Degree: University of Benin, Nigeria

Name of University Affiliation (if applicable): * _____

Street Address: 01 Queen Elizabeth Rd, Mokola, Ibadan

City: _____ **State/Province:** _____ **Country of citizenship during medical education:** Nigerian

Language(s) of Instruction: English

Type of Degree: ☐ M.D. ☐ D.O. ☐ M.D./Ph.D ☒ M.B.B.S. ☐ M.B.B.Ch ☐ Other: _____ (specify)

Date Degree The date you officially received your degree after all prerequisite obligations, required training, government service, etc.

Was Conferred: was satisfied. Month 06 Day 30 Year 87 * D.O.B. Correct 1988

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada)
Attach the following documents to this application:

1) **A copy of your valid ECFMG certificate or Fifth Pathway Certificate;**

2) **A copy of your medical school diploma and a certified translation;**

3) **If you listed an affiliation above (see * in 10 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate. The certificate must include your name, name of the medical school, name of the university, and a certified translation .**

If your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change; Passport, INS card, birth certificate, court document, marriage license, court decree.

11. **How have you satisfied Maryland's *written and oral* English language competency requirements?**
(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

a. ☒ I graduated from a medical school or, after at least three years of attendance, a high school (includes GED), undergraduate college, or university **where English was the *only* language of instruction throughout** (you must provide documentation); or

b. ☐ I passed either ☐ the TOEFL or ☐ the ECFMG English test after December 31, 1973 AND I passed the ☐ TSE or ☐ OPI. If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board;

c. ☐ I passed the USMLE Step 2 Clinical Skills Exam.

RECEIVED AUG [illegible] BOARD OF [illegible]

Are you claiming speech impairment? ☒ NO ☐ YES If "YES," please write or call the Board for additional information.

Initial Medical Licensure
POSTGRADUATE TRAINING
10/2008 INT

Print Your Name: Charles John Nosa Akoda Date: 7/28/11

12. **POSTGRADUATE TRAINING** (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order **ALL** postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider **full time teaching in an LCME accredited medical school in the United States** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this application.

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education *after* successfully completing a Board approved Fifth Pathway program. If you have not met these two criteria, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete another year of ACGME/AOA accredited clinical postgraduate training in addition to the year(s) usually required by Maryland. **All** of the additional year must have begun after the date of the last fail. Teaching will not be accepted as an alternative to a year required following three or more fails. If you have not met this requirement, DO NOT submit this application. If you failed any part, step, or component of a medical exam four times, DO NOT SUBMIT THIS APPLICATION; you are not eligible for medical licensure in Maryland.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

PG Year #s	Place of Training / Address	Specialty	From (month/year)	To (month/year)	Accredited by
4	Place of Training: HOWARD HOSPITAL Address: 2041 Georgia Ave NW DC 20060	OBGYN	06 07	06 11	ACGME ☑ AOA ☐ RCPSC ☐
	Place of Training: Address:				ACGME ☐ AOA ☐ RCPSC ☐
	Place of Training: Address:				ACGME ☐ AOA ☐ RCPSC ☐
	Place of Training: Address:				ACGME ☐ AOA ☐ RCPSC ☐
	Place of Training: Address:				ACGME ☐ AOA ☐ RCPSC ☐

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

RECEIVED
AUG 11 2011
MARYLAND BOARD OF PHYSICIANS

13. **Hospital Privileges After Postgraduate Training:** Please list all hospitals where you have had privileges or have provided services after the completion of your postgraduate training for the five year period preceding the filing of this application. Copy this page if more space is needed and enclose each signed and dated addition.

Hospital:	month year TO month year
Complete Address:	Department
Hospital:	month year TO month year
Complete Address:	Department
Hospital:	month year TO month year
Complete Address:	Department
Hospital:	month year TO month year
Complete Address:	Department
Hospital:	month year TO month year
Complete Address:	Department
Hospital:	month year TO month year
Complete Address:	Department
Hospital:	month year TO month year
Complete Address:	Department
Hospital:	month year TO month year
Complete Address:	Department
Hospital:	month year TO month year
Complete Address:	Department
Hospital:	month year TO month year
Complete Address:	Department
Hospital:	month year TO month year
Complete Address:	Department

Just Finished residency.

Initial Medical Licensure
MEDICAL EXAMS
10/2009 INT

Print Your Name: Charles John Nosa Akoda Date: 7/28/11

14. **Medical Licensing Examinations** (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1965) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations.**

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send the complete medical licensing examination history and scores directly to this Board. In each examination category below, you will find information to help you contact the administering authority.

a. Have you ever failed any medical licensing examination (or part, step, or component thereof)? NO

b. Have you failed any medical licensing examination (or part, step, or component thereof) three or more times? NO

If you answered "Yes" to a. and b., you must have successfully completed another year of ACGME-accredited clinical postgraduate training, in addition to the year(s) of training usually required for licensure in Maryland. No part of the additional year may have been taken before the date of the last fail. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.
IF YOU HAVE FAILED ANY PART, STEP, COMPONENT OR APPROVED EXAMINATION COMBINATION MORETHAN 3 TIMES, You may not be eligible for medical licensure in Maryland. For a complete explanation see COMAR 10.32.01.03 Licensure---Qualifications for Initial Licensure

a. **State Board Examination List state(s):** N/A
STATE BOARD DOES NOT INCLUDE STEP 3 OF USMLE, ORAL EXAMS, OR INTERVIEWS. State Board Examinations were licensing exams given by individual states. State Board Examinations taken after December 31, 1964 are not accepted for licensure in Maryland.
Send a copy of MBP IML7, *State Board Licensure and Examination Certification,* form to the state(s) which administered your licensing exam and ask the state(s) to send your exam results directly to the Maryland Board of Physicians. Also send a copy to each state that has ever issued you a license. **NOTE: Many states charge a fee for exam transcripts. Contact each state board prior to sending form IML7, as all fees are the responsibility of the applicant.**

Federation of State Medical Boards (See Page 8 if you took a combination of these exams or combined either with the NBME exams)

b. ☐ FLEX-Weighted Average: **All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days). Flex weighted average exams taken in more than one sitting must have current ABMS or AOA Board Certification unless you are currently certified by a member board of the American Board of Medical Specialties.**

c. ☐ FLEX Components 1 and 2: **Examinations must be passed within 5 years of each other.**

d. ☒ USMLE Steps 1, 2, and 3: **Passing scores on all parts must have been completed within a 10-year period beginning with the month and year when the applicant first passed either step 1 or step 2.**

If you took any of the above examinations you must ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Board by accessing their website at www.fsmb.org. *Click transcript requests.*

e. ☐ **National Board of Medical Examiners** (See Page 8 if you combined this examination with FLEX or USMLE exams)

If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification *and* the Record of Scores. All requests must be made through the NBME website at **http://www.nbme.org** or call 215-590-9592. If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores.

f. ☐ **National Board of Osteopathic Medical Examiners Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.** If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and the complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

g. ☐ **Medical Council of Canada**
Licentiate of the Medical Council of Canada
Please request that verification of your Licenciate Certification and a complete LMCC examination history be sent directly to this Board. Call MCC at 613-521-6012 for instructions and fee information.

CONTINUED ON PAGE 8

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

Passing scores on all parts of hybrid examinations must have been completed within a 10-year period, beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.

h. ☐ USMLE 1 + NBME II + NBME III

i. ☐ USMLE 1 + USMLE 2 + NBME III

j. ☐ USMLE 1 + NBME II + USMLE 3

k. ☐ NBME I + USMLE 2 + USMLE 3

l. ☐ NBME I + USMLE 2 + NBME III

m. ☐ NBME I + NBME II + USMLE 3

n. ☐ FLEX 1 + USMLE 3

o. ☐ FLEX 2 + USMLE 1 + NBME II

p. ☐ FLEX 2 + USMLE 1 + USMLE 2

q. ☐ FLEX 2 + NBME I + USMLE 2

r. ☐ FLEX 2 + NBME I + NBME II

- If your hybrid exams included any part of the NBME examination, contact NBME at http://www.nbme.org or call 215-590-9592 for instructions and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Maryland Board of Physicians.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at www.fsmb.org.

15. Licensing History:

a. ☐ I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.

b. ☒ I have an application for license pending in the following states: LA

c. Please list below all licenses ever issued to you by a U. S. state/territory or Puerto Rico. Also list all Canadian licenses and registrations.

d. Has any disciplinary action ever been taken against your license? ☒ No ☐ Yes If yes, please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked
Virginia	0101250081	✓					

RECEIVED AUG 11 2011 MARYLAND BOARD OF PHYSICIANS

(If more space is needed, please attach an additional signed and dated sheet.)

16. Check YES or NO.

- [x] [ ] Did you successfully complete a medical licensing exam (USMLE, NBME, etc.) within the 15-year period prior to filing this application?
- [x] [ ] During the past 10 years, have you maintained uninterrupted licensure since you were first issued a license in the United States, its territories, Puerto Rico, or Canada ?
- [ ] [x] Do you have lifetime certification from, or within the past 10 years have you been certified or recertified by, a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada?

If "YES," in which specialty were you certified? _____ Date certified _____

⇒ **If you have answered "NO" to all three of the above questions, you MUST take the Special Purpose Examination. After you submit this application, contact the Federation of State Medical Boards at 817-571-2949 and arrange to take the SPEX in Maryland, and have scores sent to the Maryland Board directly.**

17. **Character and Fitness Questions** (Check either YES or NO)

	YES	NO	
a.			Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, denied your application for licensure, reinstatement, or renewal?
b.			Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment, reprimand, suspension, or revocation. Refer to the document *Grounds for Board Action in Maryland* at the Board's website www.mbp.state.md.us.
c.			Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?
d.			Have you ever withdrawn your application for a medical license or other health professional license?
e.			Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?
f.			Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way?
g.			Have you committed a criminal act to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement?
h.			Have you committed an offense involving alcohol or controlled dangerous substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgement? Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.
i.			Excluding minor traffic violations, are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?
j.			Do you illegally use drugs?
k.			Do you have any physical or mental condition that currently impairs your ability to practice medicine or that would cause reasonable questions to be raised about your physical, mental, or professional competency?
l.			Have you ever been named as a defendant in a medical malpractice action?
m.			Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?
n.			Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?
o.			Has your employment by any hospital, HMO, other health care facility or institution, or military entity been terminated for disciplinary reasons?
p.			Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
q.			Has use of drugs and/or alcohol ever resulted in an impairment of your ability to practice your profession?
r.			Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction or any entity of the armed services?

RECEIVED AUG 11 2011 MARYLAND BOARD OF PHYSICIANS

»» **If you answered "YES" to any of the questions in item 17, on the following page please list all adverse actions taken against you and provide a complete explanation. Attach any supporting documentation that applies (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgements, or final orders). Sign and date all pages submitted.**

medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

Charles John Nosa Akoda — Charles Akoda — 7/28/11

Applicant's Name (Printed) — Applicant's Signature — Date

20. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: N/A

Phone:

Applicant's Signature — Date

21. I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

Applicant's Signature — 7/28/11 Date

22. Affidavit: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-22 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

Applicant's Signature — 8/3/11 Date

RECEIVED AUG 11 2011 Maryland Board of Physicians

STATE OF Maryland

CITY/COUNTY OF Prince George's

I HEREBY CERTIFY that on this 3rd day of August, 20 11, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, Charles Akoda (print applicant's name), whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notorial seal. Notary Public

My Commission expires: 03-25-2012 SEAL

GEORGE E. OKAI
NOTARY PUBLIC
PRINCE GEORGE'S COUNTY, MARYLAND
MY COMMISSION EXPIRES 3-25-2012

STOP! Completed application and check must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297

BENIN CITY, NIGERIA

Johnbull Enosakhare Akoda

having satisfied all the requirements of the University and passed the prescribed examinations held in

October 1987

has been admitted to the degree

of

Bachelor of Medicine: Bachelor of Surgery

Given at Benin City this 6th day of February 1988

REGISTRAR

VICE-CHANCELLOR

EDUCATIONAL COMMISSION
for
FOREIGN MEDICAL GRADUATES

CERTIFIES THAT

— JOHN NOSA AKODA

HAS SATISFIED ALL THE REQUIREMENTS OF THE COMMISSION,

SUCCESSFULLY PASSED ITS EXAMINATIONS

RECEIVED AND HAS BEEN AWARDED THIS CERTIFICATE.

CERTIFICATE NUMBER 0-553-258-5

MEDICAL EXAMINATION

BASIC SCIENCE JUNE 11, 1997

CLINICAL SCIENCE AUGUST 28, 1996

ENGLISH EXAMINATION AUGUST 28, 1996

VALID THROUGH

CERTIFICATE NUMBER
0-553-258-5
ENGLISH EXAMINATION
August 28, 1996
VALID INDEFINITELY

CHAIRMAN, BOARD OF TRUSTEES

PRESIDENT, CHIEF EXECUTIVE OFFICER

DATE ISSUED AUGUST 18, 1997

HOWARD UNIVERSITY HOSPITAL AND AFFILIATED HOSPITALS
WASHINGTON, DISTRICT OF COLUMBIA

THIS IS TO CERTIFY THAT

JOHN-CHARLES NOSA AKODA, MD

HAS SATISFACTORILY COMPLETED FOUR YEARS
OF POSTGRADUATE MEDICAL EDUCATION IN

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

THROUGH OUR TRAINING PROGRAMS AT HOWARD UNIVERSITY.
JULY 1, 2007 - JUNE 30, 2011

Fannie E. Brown
DIRECTOR, GRADUATE MEDICAL EDUCATION

PROGRAM DIRECTOR

VERITAS · HOWARD UNIVERSITY · WASHINGTON, D.C. · 1867

Sidney Ribeau
PRESIDENT OF THE UNIVERSITY

Cortés H. Rampersad-Cowan
SECRETARY OF THE UNIVERSITY

BENIN CITY, NIGERIA

Johnbull Enosakhare Akoda

having satisfied all the requirements of the University and passed the prescribed examinations held in

October 1987

has been admitted to the degree

of

Bachelor of Medicine: Bachelor of Surgery

Given at Benin City this 6th day of February 1988

REGISTRAR

VICE-CHANCELLOR

Initial Medical Licensure
Supplemental Form
MBP IML3
10/2000 INT

MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O.Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 800-492-6836

Side A

VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Part 1 APPLICANT: Complete Part 1 and sign where indicated in the Part 2 instructions. Print your name on top of the reverse page, and send a form to the director of each postgraduate training program you attended. Be sure to copy both sides.

a. Applicant's Name: AKODA CHARLES JOHN NOSA
(Last Name and Generational Indicator (Jr., Sr., II, III, etc.) First Name Middle Name)

Address:

City: State:

Date of Birth: Month Day Year Social Security Number:

b. Name of Institution: HOWAR UNIVERSITY HOSPITAL
Department and Area of Training: OBSTETRICS AND GYNECOLOGY
Complete Address: 2041 Georgia Avenue, NW
City: Washington State: DC
FROM: Month 07 Year 07 TO Month 06 Year 11

Part 2 POSTGRADUATE TRAINING PROGRAM DIRECTOR: Please complete Part 2 according to the records available and send directly to the Maryland Board of Physicians at the above address. Please do not send original or copies to me. Applicant's Signature

1. Did the applicant participate in postgraduate training in your department during the period listed above?*
☑ YES ☐ NO If "No," please enter exact dates: _____ to _____
Program Specialty: OBGYN

*If training was part-time, please explain the training schedule after item 8 of this form.

RECEIVED AUG – 9 MARYLAND BOARD OF PHYSICIANS

2. During the time of the applicant's participation, was the postgraduate training program accredited? ☑ YES ☐ NO
Accredited by: ☑ ACGME: Program # 2201021065 ☐ AOA: ID #: _____ ☐ RCPSC

3. Did the applicant participate in all of the components of the training as required by the accrediting body?
☑ YES ☐ NO Comments (attach signed and dated additions as needed): _____

4. Did the applicant successfully complete all requirements of each year of training?
☑ YES ☐ NO Comments (attach signed and dated additions as needed): _____

5. During the applicant's year(s) of training, did the applicant have any break in training?
☑ NO ☐ YES Comments (attach signed and dated additions as needed): _____

18 a. If you answered "YES" to any of the questions in item 17, please provide an explanation below and attach all complaints, pleadings and judgments. Attach additional signed and dated pages as needed.

18 b. If you answered yes to 17L - answer the following questions:

1. Total number of malpractice claims ever filed in which you were named as a defendant?_____
2. Total number of malpractice claims ever paid (settlement / judgment) in which you were named as a defendant? _____
3. Within the last 60 months (5 years) provide the following:
   Total number of medical malpractice claims filed _____ ; paid (settlement / judgment) _____;
   or dismissed_____; in which you were named as a defendant.
4. For a claim filed at any time, but paid (settlement / judgment) within the last 60 months (5 years), list each claim by claimants name; describe the disposition of each claim; and provide a copy of the complaint, pleading, and judgment of each medical malpractice claim.

N/A

RECEIVED AUG 11 2011 MARYLAND BOARD OF PHYSICIANS

I have attached the following number of pages to this application:_____

Date:

9. Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

Date Medical School was Completed: month/year: 06 87

Activities after completing medical school: Please type or print.

From (month/year)	To (month/year)	Activity	Address
06 07	06 11	OBGYN RESIDENCY	HOWARD HOSP 2041 GEORGIA AVEN. NW DC 20060
01 05	06 07	MAXICARE INC PHYSICIAN ASSISTANT	P.O. BOX 5036, Laytonsville MD 20882
05 00 (2000)	12 04	MEDICAL DIRECTOR Vita Med ctr	Port Harcourt, Nigeria.
07 92	04 00	MEDICAL OffICER	Gen Hosp Ughelli, Nigeria
06 90	06 92	Resident OBGYN	University of Ibadan, Nigeria.
01 89	05 90	Medical officer	Gen. Hosp. Benin City, Nigeria
07 87	12 88	Internship	Gen. Hosp. Warri, Nigeria.

RECEIVED AUG ... 20.. MARYLAND BOARD OF PHYSICIANS

CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

MARYLAND BOARD OF PHYSICIANS
WILLIAM CALHOUN
4201 PATTERSON AVE., 4TH FLOOR
BALTIMORE, MD, 21215-0095

State Board Code:
021
Please include this number on all requests

ECFMG® CERTIFICATION STATUS REPORT

USMLE™/ECFMG Identification Number: 0-553-258-5
Applicant's Name: JOHN NOSA AKODA
Applicant's Date of Birth: 01/01/1959
ECFMG Certified:Yes
Certificate Issue Date: 08/18/1997
English Test Valid Through: Valid Indefinitely

Passing Performance on Medical Science Examinations:

Examination	Date	Two Digit Score	Three Digit Score
USMLE Step 1	11 Jun 1997	*	*
USMLE Step 2 CK	28 Aug 1996	*	*

Most Recent Passing Performance on Clinical Skills Examination:

Examination	Date
Not Required for Certification	

Most Recent Passing Performance on English Test: AUG 1996
Name of Medical School and Country:University of Benin College of Medicine, Benin, NIGERIA

Degree Year: 1988
† Medical Education Credentials Status: Complete
This information is reported directly from ECFMG computer records and is current as of 09/14/11.

How to Verify the Authenticity of this Report:

This report was issued to the named recipient on the date shown below. To verify the authenticity of this report, visit https://cvsonline2.ecfmg.org/verify/verify.aspx and enter the unique verification code at the bottom of the report. The information contained in this report is current as of the issue date. Any changes to the physician's status after the issue date will not be reflected, and you are encouraged to request an updated report.

The purpose of this Status Report is to indicate whether this individual is certified by ECFMG. It reflects only examinations that were used to fulfill requirements for ECFMG Certification. The most recent passing performance on the clinical skills examination is reflected, regardless of whether this individual was required to take a clinical skills examination for ECFMG Certification. This Status Report is not a complete score history of all examinations for this individual. This Status Report does not include examinations that were taken but not passed. Furthermore, if this individual passed examinations that were not used to fulfill the requirements for ECFMG Certification, these examinations are not included.
* To obtain a complete history of and scores for USMLE Step examination(s) that may have been taken by this individual, contact the appropriate registration entity to request a USMLE transcript.

† Since July 1986, ECFMG has verified medical school credentials directly with the medical schools, or through a reasonable alternative that has been approved by the ECFMG Medical Education Credentials Committee.

Important Note:

Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization.

Report Verification Code: DXD0C14D9F

Initial Medical Licensure
Supplemental Form
MBP IML3
10/2009 INT

MARYLAND BOARD OF PHYSICIANS
VERIFICATION OF POSTGRADUATE MEDICAL EDUCATION

Side B

Applicant's Name (print): John Charles Nosa Akoda

6. Did the applicant have any physical or mental problem that affected the applicant's ability to practice medicine during the period of training?

___ ___ If "Yes," please give a detailed explanation* _____

7. Was any action taken against the applicant by any training program, hospital, medical board, licensing authority, or court ? Such actions include, but are not limited to investigations, limitations of privileges or special conditions, requirements imposed for academic incompetence, disciplinary actions, probationary actions, etc.

[illegible] If "Yes," please give a detailed explanation* _____

8. In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program?

☑ YES ☐ NO Comments:*

Control No: 111179 08/09/2011
Akoda, Charles John Nosa
IML3-Accredited Training Programs
Received: William Calhoun
Analyst: Dierdra Rufus

*** If space is not sufficient, please attach a signed and dated detailed explanation.**

Attestation: I attest that the information I have provided regarding the applicant is true, accurate, and complete according to all available records.

Diana Broom Field — M.D., FACOG, FACS
Printed Name of Program Director — Title
Howard University — 2041 Georgia Ave. Washington DC
Hospital — Address
[illegible] — 202-865-7081

10. **MEDICAL EDUCATION:** List all medical schools you have attended — From: MM/YY To MM/YY

University OF BENIN COLLEGE OF MEDICINE, NIGERIA — 06/82 - 06/87

Medical School From Which You Received Your Medical Degree: University of Benin, Nigeria

Name of University Affiliation (if applicable): *

Street Address: 01 QUEEN ELIZABETH Rd, MOKOLA, Ibadan

City: _____ **State/Province:** _____ **Country of citizenship during medical education:** Nigerian

Language(s) of Instruction: ENGLISH

Type of Degree: ☐ M.D. ☐ D.O. ☐ M.D./Ph.D ☒ M.B.B.S. ☐ M.B.B.Ch ☐ Other: _____ (specify)

Date Degree The date you officially received your degree after all prerequisite obligations, required training, government service, etc.

Was Conferred: was satisfied. Month 06 Day 30 Year 87 * D.O.B. 1988 Correct

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada)
Attach the following documents to this application:

1) **A copy of your valid ECFMG certificate or Fifth Pathway Certificate;**

2) **A copy of your medical school diploma and a certified translation;**

3) **If you listed an affiliation above (see * in 10 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate. The certificate must include your name, name of the medical school, name of the university, and a certified translation .**

If your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change; Passport, INS card, birth certificate, court document, marriage license, court decree.

11. **How have you satisfied Maryland's *written and oral* English language competency requirements?**
(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

a. ☒ I graduated from a medical school or, after at least three years of attendance, a high school (includes GED), undergraduate college, or university **where English was the *only* language of instruction throughout** (you must provide documentation); or

b. ☐ I passed either ☐ the TOEFL or ☐ the ECFMG English test after December 31, 1973 **AND** I passed the ☐ TSE or ☐ OPI. If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board;

c. ☐ I passed the USMLE Step 2 Clinical Skills Exam.

Are you claiming speech impairment? ☒ NO ☐ YES If "YES," please write or call the Board for additional information.

RECEIVED AUG [illegible] AND BOARD OF [illegible]

2014

Print

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

1. **License Number D0073049** Dr. Charles John Nosa Akoda

2. Individual National Provider Identifier NPI: 1952664278 ☐ I do not have an NPI
This is the NPI entered in the field for Rendering NPI on a claim (10 digit number)
NPI Information

3. **EMAIL ADDRESS**: Please enter your most current email address where we may contact you regarding your license.
adcfrancis@aol.com

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2014 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. **Non-Public Address**: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street
Street (2)
Street (3)
City
State
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode
Country

4b. **Public Address**: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street: 14909 Downey Court
Street (2):
Street (3):
City: Bowie
State: Maryland
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode: 20721
Country: United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2012. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.

Yes No NO — Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes No NO — Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

Yes No
NO

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes No
NO

s an investigation or charge been brought against you by a hospital, related institution, or alternative health re system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

Yes No
NO

ve you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes No
NO

Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

Yes No
NO

. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

re there any pending criminal charges against you in any court of law, excluding minor traffic violations?

Yes No
NO

Do you have a physical or mental condition that currently impairs your ability to practice medicine?

Yes No
NO

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

Yes No
NO

Do you illegally use drugs?

Yes No
NO

. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

Yes No
NO

Have you been named as a defendant in a filing or settlement of a medical malpractice action?

Yes No
YES

I was a Resident rotating through Prince Georges Hospital in 2010 when a child delivered had Brachial nerve palsy. All staff including Residents involved in the delivery were name in the law-suit. I am being represented by Attorneys from Howard Residency program which is my training institution. The law-suit is still in its preliminary stages

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?

Yes No
NO

ve you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military ntity while under investigation by that institution for disciplinary reasons?

Yes No
NO

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

Yes No
NO

. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

Yes No

CONTINUING MEDICAL EDUCATION (Question 7)

◉ **a. CME met.** I have completed and have been granted credit for at least 50 credit hours of Category 1 continuing medical education activities within the two-year period immediately preceding submission of this application for license renewal. *Physician is obliged to obtain requisite documentation of CME activity and maintain documentation for a period of six years for possible inspection by the Board. For additional information on CME, see Maryland Regulations, 10.32.01.09.*

○ **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2012 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

○ **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8a. Gender ◉ Male ○ Female

8b. RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY

Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

nerican Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)

ian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

or African American (A person having origins in any of the black racial groups of Africa.)

ive Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

ite (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

ner

---

9. Are you employed by the Federal Government?

○ Yes ◉ No

---

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer **Yes** to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

○ Yes ◉ No

b. In an accredited fellowship (subspecialty) training program?

○ Yes ◉ No

11a. Which best describes your current area(s) of concentration:

Primary Concentration: Obstetrics & Gynecology

Secondary Concentration: None

11b. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: Obstetrics & Gynecology
Secondary Certification: None

12. Please select all states (excluding Maryland) where you hold a medical license.

☐ Alabama	☐ Florida	☐ Kentucky	☐ Nebraska	☐ Oklahoma	☐ Utah
☐ Alaska	☐ Georgia	☐ Louisiana	☐ Nevada	☐ Oregon	☐ Vermont
☐ Arizona	☐ Guam	☐ Maine	☐ New Hampshire	☐ Pennsylvania	☑ Virginia
☐ Arkansas	☐ Hawaii	☐ Massachusetts	☐ New Jersey	☐ Puerto Rico	☐ Virgin Islands
☐ California	☐ Idaho	☐ Michigan	☐ New Mexico	☐ Rhode Island	☐ Washington
☐ Colorado	☐ Illinois	☐ Minnesota	☐ New York	☐ South Carolina	☐ West Virginia
☐ Connecticut	☐ Indiana	☐ Mississippi	☐ North Carolina	☐ South Dakota	☐ Wisconsin
☐ Delaware	☐ Iowa	☐ Missouri	☐ North Dakota	☐ Tennessee	☐ Wyoming
☐ District of Columbia	☐ Kansas	☐ Montana	☐ Ohio	☐ Texas	

13a. How many weeks per year do you work? 48

13b. Please indicate below how the hours are allocated in your typical work week . The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes the teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	60	hours per week
b. Research	0	hours per week
c. Teaching	10	hours per week
d. Administration & Other	10	hours per week
Total Hours	80	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next two years?

○ Yes ○ No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

○ Yes ◉ No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) 2

b. 0

Number of locations outside of Maryland (if none, enter 0)
If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?
○ Yes ○ No ○ Don't know

---

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) 1

b. Number of hospitals outside of Maryland (if none, enter 0) 0

---

18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name: Dr Abdul Chaudry

Organization Name2:

b. Street Address: 6005 Landover Road, suite#5

c. Street2:
Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City: Cheverly

e. State: Maryland

f. Zip Code: 20785

g. Jurisdiction: PRINCE GEORGE'S

---

h. Employer Tax ID: 00 - 0000000 If you do not have an EIN enter 00-0000000
What is Employer tax ID?

---

i. Please select one of the following related to the NPI used for billing insurers:

○ I use an Organizational NPI for billing. Please Enter > Organizational NPI

○ I use my Individual NPI for billing.

◉ I do not bill public or private insurers.

---

j. You indicated in Question 13a, **60** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? 60 Hours
If none, enter 0.

---

k. Setting: Freestanding Physician Office

l. Private/Public: Private-For profit

m. Practice: Single-Specialty Group-independent

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.
If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 2

Number of mid-level medical providers at this location. 5
Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

---

19. Secondary Practice / Office Location

If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

a. Organization Name: Dr Abdul Chaudry

Organization Name2:

b. Street Address: 6400 Marlboro Pike

c. Street2:

Enter suite or room number (Ex. Suite 101 or Room 101)

d. City: District Heights

e. State: Maryland

f. Zip Code: 20747

g. Jurisdiction: PRINCE GEORGE'S

---

h. Employer Tax ID: 00 - 0000000 If you do not have an EIN enter 00-0000000

What is Employer tax ID?

---

i. Please select one of the following related to the NPI used for billing insurers:

- ○ I use an Organizational NPI for billing. Please Enter > (Organizational NPI)
- ○ I use my Individual NPI for billing.
- ◉ I do not bill public or private insurers.

---

j. You indicated in Question 13a, **60** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? 20 Hours
If none, enter 0.

---

k. Setting: Freestanding Physician Office

l. Private/Public: Private-For profit

m. Practice: Solo-independent

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.
If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 2

Number of mid-level medical providers at this location. 5

Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

20-21 The Health Information Technology questions have been moved to a seperate section. You are required to complete the Health Information Technology section ONLY if you have a Primary Practice Location.

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. ◉ Yes ○ No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) ◉ Yes ○ No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? ◉ Yes ○ No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)?

◉ Yes ○ No

c1. If Yes, are you accepting new Medicare patients? ◉ Yes ○ No

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

○ Yes ○ No ◉ NA

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

0 hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), please answer Q.25, otherwise:

☑ check this box and skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel, sometimes called direct, concierge, or retainer-based practice?

○ Yes ○ No

26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

◉ Not Applicable (Do not complete below)

○ I do not practice in Maryland.

○ I do not employ anyone in my practice in Maryland.

○ I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date Enter as MM/DD/YYYY Enter as MM/DD/YYYY

HEALTH INFORMATION TECHNOLOGY

Please contact the Maryland Health Care Commission at 410-764-3330 for questions relating to this section.

Electronic Health Record Incentive

Beginning in 2011, physicians that adopt an electronic health record are eligible to receive an incentive either under Medicare or Medicaid. To receive this incentive, a physician must meet certain criteria, which varies depending on which program you choose. The Medicare incentive is up to $44,000 over five years and the Medicaid incentive is up to $63,750 over six years. Physicians are encouraged to learn more about these incentive opportunities by visiting the Centers for Medicare and Medicaid Services website http://www.cms.gov/EHRIncentivePrograms/

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in
Question 18 - Primary Practice / Office Location Primary Practice / Office Location

Please complete the following HIT questions for: **Dr Abdul Chaudry**

1. This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients in your office.

Are you computerized in your office:

a. To obtain information about treatment alternatives or recommended guidelines?

◉ Yes ○ No

b. To send prescriptions electronically to a pharmacy?

◉ Yes ○ No

If you answered Yes to 1b, what percentage of prescriptions are submitted electronically? 90 %
(Enter Whole number)

c. To generate reminders for you about preventive services needed for your patients?

◉ Yes ○ No

d. To access patient notes, medication lists, or problem lists?

◉ Yes ○ No

e. For clinical data and image exchanges with other physicians?

○ Yes ◉ No

f. For clinical data and image exchanges with hospitals and laboratories?

○ Yes ◉ No

g. To communicate about clinical issues with patients by email?

○ Yes ◉ No

h. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

◉ Yes ○ No

2. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

○ Yes, all electronic ◉ Yes, part paper and part electronic ○ No ○ Don't know

2a. If Yes, what is the name and version of the EHR system?

Other

Other Lytec

2b. If **No,** please indicate your most significant reason for not using electronic medical records.

○ Capital cost outlays ○ Lack of technology standards ○ Retiring soon
○ Overburdened staff ○ Intangible benefits ○ Not my decision
○ Risk of privacy breaches

3. Have you used telemedicine for any purpose in the last 12 months?

◉ Yes ○ No

Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications of electronic technology by a licensed health care provider to deliver health care service(s) within the scope of practice of the health care provider at a site other than the site at which the patient is located.

3a. Approximately how many times in the last 12 months have you used telemedicine for any purpose? 2
(Enter 0 if you did not use telemedicine)

3b. If you used telemedicine, what are your common uses of telemedicine technology (mark all that apply)?

☐ Second opinion
☐ Diagnosis
☑ Follow up
☐ Emergency
☐ Chronic disease management
☐ Other (specify)

The following questions are to be answered ONLY if your Practice Setting is one of the following:
(1) Solo; (2) Single-Specialty Group; (3) Multi-Specialty Group; or (4) HMO Group/Staff

4. Does your practice use high speed Internet?

(•) Yes ( ) No

4a. Comcast *Please Specify* :

5. How do you access the Internet?

( ) DSL ( ) Cable Modem ( ) Fiber to the office (•) Wireless ( ) Other ( ) Unknown

6. Do you provide Wi-Fi access to your patients in your waiting area?

( ) Yes (•) No ( ) Unknown

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime * 3013250264

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

☐ Chemical ☐ Biological ☐ Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☑ d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2014.

29. Please provide your electronic signature (type your name) below:

Name Charles Akoda

Today's Date 8/12/2014

Last four digits of Social Security Number:

30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

◉ Credit Card ○ Send Check ○ 3rd Party Check 3rd Party Payer:

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started	8/12/2014
Date Application Submitted	8/12/2014
Confirmation Number	
Payment Method	Credit Card
Amount Paid	$522.00
Credit Card Approval No.	

2012

Print

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

1. **License Number D0073049** Dr. Charles John Nosa Akoda

2. Individual National Provider Identifier NPI: 1952664278 ☐ I do not have an NPI
This is the NPI entered in the field for Rendering NPI on a claim (10 digit number)
NPI Information

3. **EMAIL ADDRESS**: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

adcfrancis@aol.com

☐ I do not have an email address

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2012 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. **Non-Public Address**: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street
Street (2)
Street (3)
City
State
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode
Country

4b. **Public Address**: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street: 14909 Downey Court
Street (2):
Street (3):
City: Bowie
State: Maryland
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode: 20721
Country: United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2010. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.

Yes No NO — Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

Yes No — Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

NO

Yes No Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
NO

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?
Yes No
NO

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?
Yes No
YES

Yes due to NPI number error: On February 2012 I applied for Hospital priviledges at Prince Georges Hospital. I inadvertently supplied an organizational NPI number rather than an Individual NPI number. My priviledges were rescinded on about May 30th 2012. I have since obtained an individual NPI number 1952664278 which I have submitted to the hospital. I am in the process of re-credentialing.

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?
Yes No
NO

Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?
Yes No
NO

Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?
Yes No
NO

Do you have a physical or mental condition that currently impairs your ability to practice medicine?
Yes No
NO

Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?
Yes No
NO

Do you illegally use drugs?
Yes No
NO

Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?
Yes No
NO

Have you been named as a defendant in a filing or settlement of a medical malpractice action?
Yes No
NO

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?
Yes No
YES

Yes due to NPI number error On February 2012 I applied for Hospital privileges at Prince Georges Hospital. I inadvertently supplied an organizational NPI number rather than an Individual NPI number. My privileges were rescinded on about may 30th 2012. I have since obtained an individual NPI number 1952664278 which I have submitted to the hospital. I am in the process of re-credentialing.

Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
Yes No
NO

Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?
Yes No

Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

Yes No

NO

CONTINUING MEDICAL EDUCATION (Question 7)

○ **a. CME met.** I have completed and have been granted credit for at least 50 credit hours of Category 1 continuing medical education activities within the two year period immediately preceding submission of this application for license renewal. *Physician is obliged to obtain requisite documentation of CME activity and maintain documentation for a period of six years for possible inspection by the Board. For additional information on CME, see Maryland Regulations, 10.32.01.09.*

◉ **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2010 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

○ **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8a. Gender ◉ Male ○ Female

8b. RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY

Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Select one or more of the following racial categories:

erican Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)

n (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

or African American (A person having origins in any of the black racial groups of Africa.)

e Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

ite (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

er

---

9. Are you employed by the Federal Government?

○ Yes ◉ No

---

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer ***Yes*** to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

○ Yes ◉ No

b. In an accredited fellowship (subspecialty) training program?

○ Yes ◉ No

11a. Which best describes your current area(s) of concentration:

Primary Concentration: Obstetrics & Gynecology
Secondary Concentration: None

11b. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: None
Secondary Certification: None

12. Please select all states (excluding Maryland) where you hold a medical license.

☐ Alabama	☐ Florida	☐ Kentucky	☐ Nebraska	☐ Oklahoma	☐ Utah
☐ Alaska	☐ Georgia	☐ Louisiana	☐ Nevada	☐ Oregon	☐ Vermont
☐ Arizona	☐ Guam	☐ Maine	☐ New Hampshire	☐ Pennsylvania	☑ Virginia
☐ Arkansas	☐ Hawaii	☐ Massachusetts	☐ New Jersey	☐ Puerto Rico	☐ Virgin Islands
☐ California	☐ Idaho	☐ Michigan	☐ New Mexico	☐ Rhode Island	☐ Washington
☐ Colorado	☐ Illinois	☐ Minnesota	☐ New York	☐ South Carolina	☐ West Virginia
☐ Connecticut	☐ Indiana	☐ Mississippi	☐ North Carolina	☐ South Dakota	☐ Wisconsin
☐ Delaware	☐ Iowa	☐ Missouri	☐ North Dakota	☐ Tennessee	☐ Wyoming
☐ District of Columbia	☐ Kansas	☐ Montana	☐ Ohio	☐ Texas	

13a. How many weeks per year do you work? 48

13b. Please indicate below how the hours in your typical work week are allocated. The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	36	hours per week
b. Research	0	hours per week
c. Teaching	0	hours per week
d. Administration & Other	4	hours per week
Total Hours	40	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next 2 years?

○ Yes ○ No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

○ Yes ◉ No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) 0

b. Number of locations outside of Maryland (if none, enter 0) 0

If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?

○ Yes ○ No ○ Don't know

---

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) 0

b. Number of hospitals outside of Maryland (if none, enter 0) 0

---

18. Primary Practice / Office Location Primary Practice / Office Location

No Primary Location indicated from your response in Question 16

Please answer all Primary Practice questions

---

19. Secondary Practice / Office Location

No Secondary Location indicated from your response in Question 16.

If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

20-21 Health Information Technology questions has been moved to a seperate section. You are required to complete the Health Information Technology section ONLY if you have a Primary Practice Location.

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a.	Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc.	○ Yes ◉ No
b.	Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization)	○ Yes ◉ No
	b1. If Yes, are you accepting new Maryland Medical Assistance patients?	○ Yes ○ No
c.	Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)?	○ Yes ◉ No
	c1. If Yes, are you accepting new Medicare patients?	○ Yes ○ No

---

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

○ Yes ○ No ◉ NA

---

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

0 hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?

○ Yes ○ No

---

26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

○ Not Applicable (Do not complete below)

○ I do not practice in Maryland.

○ I do not employ anyone in my practice in Maryland.

○ I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date Enter as MM/DD/YYYY Enter as MM/DD/YYYY

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime * 3013250264

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

☐ Chemical ☐ Biological ☐ Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☑ d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2012.

29. Please provide your electronic signature (type your name) below:

Name	Charles John Nosa Akoda
Today's Date	9/3/2012
Last four digits of Social Security Number:	

30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

(●) Credit Card ( ) Send Check ( ) 3rd Party Check 3rd Party Payer:

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started	9/3/2012
Date Application Submitted	9/3/2012
Confirmation Number	49
Payment Method	Credit Card
Amount Paid	$514.00
Credit Card Approval No.	